

FORWARDHEALTH

PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION										
1. Check only if applicable <input type="checkbox"/> HealthCheck "Other Services" <input type="checkbox"/> Wisconsin Chronic Disease Program (WCDP)				2. Process Type 120			3. Telephone Number — Billing Provider (XXX) XXX-XXXX			
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code) I.M. Billing Provider 609 Willow St Anytown WI 55555-1234							5a. Billing Provider Number 0222222220			
							5b. Billing Provider Taxonomy Code 123456789X			
SECTION II — MEMBER INFORMATION										
6. Member Identification Number 1234567890				7. Date of Birth — Member MM/DD/CCYY				8. Address — Member (Street, City, State, ZIP Code) 322 Ridge St Anytown WI 55555		
9. Name — Member (Last, First, Middle Initial) Member, Im A.				10. Gender — Member <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female						
SECTION III — DIAGNOSIS / TREATMENT INFORMATION										
11. Diagnosis — Primary Code and Description 770.7 — Bronchopulmonary dysplasia						12. Start Date — SOI		13. First Date of Treatment — SOI		
14. Diagnosis — Secondary Code and Description 343.9 — Infantile cerebral palsy						15. Requested PA Start Date MM/DD/CCYY				
16. Rendering Provider Number	17. Rendering Provider Taxonomy	18. Service Code	19. Modifiers				20. POS	21. Description of Service	22. QR	23. Charge
		S9124	1	2	3	4	12	RN/PDN not to exceed 12 hours per 24-hour period and 60 hours per calendar week, all members combined	3,120 hrs	XXX.XX
								Coordinator: name, license #		
								Supervising RN: name, license #		
An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.									24. Total Charges	X,XXX.XX
25. SIGNATURE — Requesting Provider I.M. Provider									26. Date Signed MM/DD/CCYY	